FORM 123

The Commonwealth of Massachusetts
Department of Industrial Accidents – Department 123
600 Washington Street – 7th Floor, Boston, Massachusetts 02111
Info. Line 800-323-3249 ext. 470 in Mass. Outside Mass. - 617-727-4900 ext. 470
http://www.mass.gov/dia

DIA BOARD NO.
§37 or §37A
Claim

Please print or type

AGREEMENT UNDER SECTION 37 or 37A

Please Note – For Injuries on or after 12/23/1991, the insurer must file their quarterly request for reimbursement within two (2) years from the date of the final approval of the Form 123. All subsequent quarterly request for reimbursements must be received by the DIA within two (2) years from the date of payment by the insurer.

EMPLOYEE	1. Employee's Name (Last, First, MI):	
	2. Home Address (No. & Street, City, State, Zip Code):	
	3. Employer's Name:	
	4. Employer's Address (No. & Street, City, State, Zip Code):	
INSURER	5. Insurance Carrier's Name:	6. Insurance Company Address:
	7. Name & Address of Person Able to Verify Information:	
	8. Telephone Number:	

9. Paid Through (mm/dd/yyyy):	10. First Date of Disability (mm/dd/yyyy):	11. If Employee Died, Enter Date of Death:

12. Total Amount to be reimbursed under Section 37 ☐ or 37A ☐ :$_____ (Check all that apply to this agreement) ☐ NEGOTIATED ☐ FULL & FINAL

13. Amount of Quarterly Reimbursements (if any): $_____

14. Is employee still receiving weekly compensation benefits? Yes ☐ No ☐ If Yes, please fill out the following

TYPE OF WEEKLY COMPENSATION	COMPENSATION AMOUNT
a. ☐ Total Disability – Temporary (§34)	$_____
b. ☐ Total Disability – Permanent (§34A)	$_____
c. ☐ Partial Disability (§35)	$_____
d. ☐ Dependent Coverage (§35A)	$_____
e. ☐ Surviving Dependents Coverage (§31)	$_____
f. ☐ Other (Specify) _____	$_____

I hereby certify that the information contained herein is a true accounting of all payments made to the above named employee.

_____ _____
Signature of Insurer's Authorized Representative — Prepared Date (mm/dd/yyyy)

_____
Name & title (Last, First, MI)

I hereby agree to and approve the following reimbursement to be made per the provisions of this agreement.

_____ _____ _____
Signature for the Office of Legal Counsel — Date (mm/dd/yyyy) — Name & title (Last, First, MI)

I hereby agree to and authorize the following reimbursement to be made per the provisions of this agreement.

_____ _____ _____
Signature for the Office of the Commissioner — Date (mm/dd/yyyy) — Name & title (Last, First, MI)